DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 7 — 0 0 1

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 1/1/97

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 97 $ 9.5 m
b. FFY 98 $ 12.0 m

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D(4)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same

10. SUBJECT OF AMENDMENT:

Nursing Facility Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

Not required under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Bruce M. Bullen

14. TITLE:
Commissioner, Division of Medical Assistance

15. DATE SUBMITTED:
3/28/97

16. RETURN TO:

Bridget Landers
Coordinator for State Plan
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 31, 1997

18. DATE APPROVED: April 3, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 1997

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Ronald P. Preston

22. TITLE:
Associate Regional Administrator, DMSO/HCFA

23. REMARKS:

OFFICIAL

FORM HCFA-179 (07-92)

Instructions on Back

The current nursing facility reimbursement system under the State Plan establishes prospective casemix rates that are reasonable and adequate to meet the costs that efficiently and economically operated facilities must incur to provide care in conformity with applicable state and federal laws, regulations, quality and safety standards, and the regulations developed by the Massachusetts Division of Health Care Finance and Policy, "Prospective Rates of Payment to Long-Term Care Facilities" 114.2 CMR 5.00, as amended from time to time. The current set of these regulations, effective January 1, 1997 are attached hereto as Appendix 1. These regulations stipulate that the rates for rate year 1997 be based on audited cost reports for rate year 1993 (the "Base Year").

I. COST REPORTING AND COST FINDING

A. Required Reports

Each provider of long-term care facility services under the State Plan must complete an annual report (the "Annual Report") containing cost information for the cost reporting year on the basis of generally accepted accounting principles and the accrual method of accounting. There are three (3) reports required: a) Nursing Facility Cost Report; b) Realty Company Cost Report; and Management Company Cost Report. All cost reporting must meet the requirements set forth in 114.*2* CMR 5.03 (*2*). There are special cost reporting requirements for Hospital Based Nursing Facilities and facilities which operate other programs such as Adult Day Health, Assisted Living or Outpatient Services. These requirements are outlined in 114.*2* CMR 5.03 (3).

B. Filing Dates: Reports

Except as provided below, Providers must file the required Cost Reports for the calendar year by 5:00 PM of April first of the following calendar year. If April 1, falls on a weekend or holiday, the reports are due by 5:00 PM of the following business day.

1. Change of Ownership. Where there has been a change of ownership, the transferor shall file the Report(s) within sixty (60) days after the transfer fo ownership. Where the transferor fails to submit the Report(s) , the Division of Health Care Finance and Policy may request the Division of Medial Assistance to withhold payment to the transferee until such reports are appropriately filed.

2. New Facilities and Facilities with Major Additions. For the first two calendar years of operation during which New Facilities and Facilities with Major Additions receive prospective rates of payment (see Section IV) herein, such facilities shall file year-end Cost Reports within sixty (60) days after the close of the calendar year.

3. Hospital-Based Nursing Facilities. A Hospital-Based Nursing Facility is a separately licensed unit housed on the premises of a facility which is licensed for both hospital and long-term-term care services, where the

long-term-term care beds were converted from licensed hospital beds or otherwise acquired. Hospital-Based Nursing Facilities must file the Report(s) on a fiscal year basis which is consistent with the filing of such facilities' hospital cost reports. The Report(s) shall be due no later than ninety (90) days after the close of the facility's fiscal year.

C. Extension of Filing Date

The Division of Health Care Finance and Policy may grant an extension, up to forty-five (45) days, for submission of the Report(s). A request for an extension must: (a) be submitted in writing to the Division of Health Care Finance and Policy by the provider and not by an agent or other representative; (b) show that exceptional circumstances exist precluding the provider from submitting the Report(s) in timely fashion; and (c) be submitted no later than 30 calendar days before the filing due date.

D. Incomplete Submission

The Division of Health Care Finance and Policy shall notify the provider within one hundred twenty (120) days of receipt of the Reports if it finds that the submission is incomplete and shall specify what additional information is required to complete the submission. The provider shall file the necessary information with the Division of Health Care Finance and Policy within twenty-five (25) days of the date of notification or by April 1 of the year the Report is filed, whichever is later. The Reports and all accompanying schedules shall be deemed to be filed with the Division of Health Care Finance and Policy as of the date the Division of Health Care Finance and Policy receives complete submission.

If the Division of Health Care Finance and Policy fails to notify the provider within the 120-day period, the submission shall be considered complete and the Report(s) and all accompanying schedules shall be deemed to be filed with the Division of Health Care Finance and Policy as of the date of receipt.

The Division of Health Care Finance and Policy's right to request additional data and information during a desk or field audit, pursuant to114.2 CMR 5.03 (see Appendix 1) is not limited by these provisions.

E. Amended Reports

The Division of Health Care Finance and Policy will not accept amended Reports unless a Provider requests, in writing, that an error be corrected within ten (10) calendar days of the date of the Notice of Proposed Rates based upon the Cost Reports. At the same time the Provider must submit amended Cost Reports clearly marked "CORRECTED" and signed by the Provider. A complete listing of all changes requested and supporting documentation must accompany the report.

F. Additional Information

In addition to requests for information and data made pursuant to a desk or field audit, the Division of Health Care Finance and Policy may seek additional information and data relating to the operations of the provider and related parties, if any. Any provider who fails to maintain records shall have excluded from its prospective rate calculation any cost or item for which records were not maintained. Any record not produced at the request of the Division of Health Care Finance and Policy shall be deemed not to have been maintained.

G. Failure to File in a Timely Manner

1. The sanction imposed for each 30-day period or any portion thereof, of which acceptable Report(s) are received after the due date, shall be a one-month delay in the new rate set for the facility for the next calendar year. Such sanction shall be imposed only when the new rates set for the facility are greater than the rates in the current year.

2. If a provider fails to file the Reports or other required information within six (6) months of the filing date, the Division of Health Care Finance and Policy shall notify the provider of this failure and the sanctions which shall be imposed. Notification shall be sent registered mail, return receipt requested. Unless the failure to file is cured, the Division of Health Care Finance and Policy will terminate the prospective per diem rate of the provider effective the following January 1. If the provider subsequently files the required reports, the termination will be rescinded by the Division of Health Care Finance and Policy.

H. Termination of Provider Contract

Whenever a provider contract between the provider and the Division of Medical Assistance is terminated, the provider shall file Reports covering the current reporting period or portion thereof covered by the contract and any other Reports required by the Division of Health Care Finance and Policy, within sixty (60) days of such termination. When the provider fails to file the required Reports in a timely fashion, the Division of Health Care Finance and Policy shall notify the provider of this failure by written notice sent registered mail, return receipt requested.

Facilities that are under the supervision of a Patient Protector Receiver appointed by court order or a trustee in bankruptcy will be treated as a termination of provider contract for purposes of this subsection. For example, if a Patient Protector Receiver is appointed on August 15,1997, the cost report for the period January 1, 1997 to August 14, 1997 and all prior Reports are due on October 15, 1997.

II. Methods and Standards Used to Determine Payment Rates

A. Prospective Per Diem Rates

The prospective rates of payments shall be established on an annual basis, as set out in 114.2 CMR 5.04 through 5.13 (see Appendix 1) and shall be

computed on a per diem basis from the Base Year Reports. Facilities which were transferred during the base year shall have their prospective rates computed from the transferor's Cost Report or by consolidating the allowable expenses from the Reports of both the transferor and transferee, as determined by the Division of Health Care Finance and Policy according to 114.2 CMR 5.04(1)(a) (see Appendix 1).

The prospective rates of payment shall be established whenever possible on the basis of on-site audited data; otherwise, they shall be established on the basis of data which has been the subject of a desk audit. Costs and expenses included in determining a provider's rates of payment are subject to all limitations and conditions set forth in 114.2 CMR 5.00 et seq. (see Appendix 1). In the case of nursing facilities which include resident care units, separate prospective per diem rates shall be computed for those beds licensed for residential care.

Facilities which have been closed and then reopened will have their Prospective Per Diem Rates computed using the Base Year cost Report(s) of the same facility. In the event that, for any reason, the Base Year cost Report(s) has not been filed, the latest available cost Report for that facility will be used. When that occurs, the Reasonable Variable Costs and Reasonable Nursing Costs will be increased by an appropriate Cost Adjustment Factor and the Administrative and General Allowance will be established at the Base Year median.

B. Computation of the Prospective Rates

1. Methodology

The Division of Health Care Finance and Policy, in computing prospective rates, shall:

a. determine the allowable and reasonable costs for each cost center;

b. divide the allowable and reasonable costs for each cost center by a divisor ***(see the following Section II B (2) a-d, for the appropriate divisor for each cost center)*** to get a per diem rate for each cost center; and

c. aggregate the various per diem rates for each cost center and add the cost adjustment factor as determined in 114.2 CMR 5.04(3) (see Appendix 1) to the per diem rates determined.

2. Divisors

Divisors used for each cost center are:

a. Nursing, Variable, and Administrative and General cost centers shall be divided by the greater of base-year (1993) patient days or ninety-six percent (96%) of licensed mean beds in the base year times days in the base year.

b. The Director of Nurses cost center divisor shall be the current licensed beds times the days in rate year times the greater of ninety-six percent (96%) or the actual utilization rate in the base year.

c. Motor Vehicle, Equity, Use and Occupancy Allowance and Miscellaneous cost center's divisor shall be the current licensed beds, including resident care units, times the days in the rate year times the greater of ninety-six percent (96%) or the actual utilization rate in the base year.

d. The divisor for Capital Costs, Fixed Costs and Depreciation (excluding motor vehicle depreciation) shall be the Constructed Bed Capacity times the days in the Rate Year times the greater of ninety-six percent (96%) or the actual utilization rate in the Base Year.

3. Cost Adjustment Factor

The cost adjustment factor ("CAF")is a multiplier which generates an amount to be added to reimbursable base-year costs. In calculating the prospective rates for long-term care facilities, the value of the cost adjustment factor multiplied by the reimbursable base-year (1993) costs, exclusive of all fixed costs shall be added to reimbursable base year costs. Where there has been a change of ownership in the base year and the prospective rates have been based on the new owner's reporting period costs pursuant to 114.2 CMR 5.04(3) (see Appendix 1), the cost adjustment factor shall be modified to reflect the number of months from the midpoint of the reporting period to the midpoint of the prospective rate period. For prospective rates effective January 1, 1997, the cost adjustment factor from 1993 through 1995 shall be 5.52%. The total CAF has a labor and non-labor component. The sources are: Most Optimistic Massachusetts CPI, and DRI Forecast based on HCFA Nursing Facility Market Basket.

C. Cost Centers

The calculation of the Prospective Per Diem Rates for each individual provider is based upon the allowable costs and expenses in each cost center under the provisions and limitations set forth in 114.2 CMR 5.04through 5.13 (see Appendix 1). The different cost centers are set forth in114.2 CMR 5.04(1b).

1. Reasonable and Allowable Nursing Costs

Reasonable nursing cost, limits, and grouping for representative sampling are described in 114.2 CMR 5.05 (see Appendix 1).

Representative Sampling. For the purposes of computing the ceiling for reasonable nursing costs, providers were grouped by three geographic regions referred to as Nursing Home Reimbursement Areas (NHRAs), as follows:

(a) NHRA 1 = Health Service Area 1;
(b) NHRA 2 = Health Service Areas 2 & 5; and,
(b) NHRA 3 = Health Service Areas 3, 4, & 6

NHRAs are three distinct geographic areas designated by HSAs for the purpose of computing the limitation on reasonable nursing costs. The Commonwealth is divided into six (6) Health Service Areas (HSAs) by the state Department of Public Health. HSA1 is Western Mass; HSA2 is Central Mass (Worcester region); HSA3 is Northeastern Mass; HSA4 is Greater Boston area; HSA5 is Southeastern Mass, including Cape Cod; and HSA6 is the North Shore area beyond Boston.

Limitations. Allowable Nursing costs shall be limited to 110% of the Median claimed Base Year nursing costs incurred by a representative sample of facilities. All claimed Base Year nursing cost in excess of the facility's peer-group ceiling shall be excluded. Pediatric nursing facilities shall not be subject to the nursing cost limitations. The determination of reasonable nursing costs allowed in the calculation of prospective rates for nursing facilities, including limitations, is set forth in 114.2 CMR 5.05 (b) (see Appendix 1).

In calculating allowable nursing costs, the facility's average cost per management minute shall be determined by dividing the claimed 1993 nursing cost per diem by the facility's average management minutes score from the Case-Mix Data. To determine the ten case-mix adjusted nursing per diem amounts the facility-specific mean minutes per case-mix category from the Case-Mix Data shall be multiplied by the facility's allowable nursing cost per management minute. If the facility-specific mean minutes per case-mix category equals zero, the industry median minutes for that category shall be used. A copy of the scale of minutes for the ten (10) Management Minute categories in effect beginning July 1, 1991 is attached as Appendix 2.

Calculation of Allowable Nursing Costs for rates effective January 1, 1997. The calculation of the 1997 Nursing rates are the case mix adjusted base year nursing home rates, as described above, increased by the cost adjustment factor of 5.52% (Section II.B.3) and increased by an additional 5.43%. ***The 5.43% increase is a 1995-1997 adjustment factor containing a labor and non-labor component. The sources are: Most Optimistic Massachusetts CPI and DRI Forecast based on HCFA Nursing Facility Market Basket.***

2. Director of Nurses

Limitations. For the position of Director of Nurses as required by the Department of Public Health, allowable cost shall be held to the limits set forth in 114.2 CMR 5.06(2) (see Appendix 1).

Reasonable Costs. Reasonable Operating Costs associated with the position of Director of Nurses shall include salary, fringe benefits, payroll taxes, and workers compensation.

Calculation of Allowable Director of Nurses Costs. The Division of Health Care Finance and Policy shall calculate the allowable 1993 Director of Nurses Costs subject to the limitation described above, and apply the Cost Adjustment Factor of 5.52% (Section II B. 3.) and increase that result by an additional 5.43%. ***The 5.43% increase is a 1995-1997 adjustment factor containing a labor and non-labor component. The sources are: Most Optimistic Massachusetts CPI and DRI Forecast based on HCFA Nursing Facility Market Basket.***

3. Reasonable Variable Costs

Reasonable variable costs, limits, and grouping for representative sampling are described in 114.2 CMR 5.07 (See Appendix 1). The limits for these reasonable variable costs are as follows:

Limits for Reasonable Variable Costs

Groups	Variable Cost Limits
(a) Group 1 = Facilities in Case-Mix Group-Light(See section 5.02 Appendix 1) and located in Health System Areas 4a and 4b;	$35.73
(b) Group 2 = Facilities in Case-Mix Group-Heavy(See section 5.02 Appendix 1) and located in Health System Areas 4a and 4b;	$37.76
(c) Group 3 = Facilities in Case-Mix Group-Light and located in Health System Areas 1, 2, 3, 5, and 6;	$34.12
(d) Group 4 = Facilities in Case-Mix Group-Heavy and located in Health System Areas 1, 2, 3, 5 and 6.	$36.46

Calculation of Allowed Variable Costs. The Division of Health Care Finance and Policy shall calculate the 1997 Allowable Variable Costs subject to the limitations set forth above, by applying the Cost adjustment Factor set forth in Section II B.3. of this plan amendment to the reasonable base year variable costs and increasing that result by 5.43%.

4. Administrative and General Costs

Administrative and General Costs are paid as an allowance. For rates effective January 1, 1997, such allowance shall be set at $9.74 per diem.

The allowance of $9.74 is the base year median for Administrative and General costs updated to 1996. However, any facility that has a Base Year Administrative and General Cost per diem that is less than this allowance shall have its allowance calculated as set forth in 114.2 CMR 5.08(4) (See Appendix 1).

5. Capital and Other Fixed Costs

The Allowable Basis of Fixed Assets is described in 114.2 CMR 5.09 (2). The Allowable Basis of Fixed Assets is used to calculate allowable depreciation, interest, equity, and use and occupancy for Method One and the Capital Allowance for Method Two, as set forth below.

The Division of Health Care Finance and Policy will classify providers into two groups in order to determine the method used for the calculation of allowable Capital and Other Fixed Costs. There is a separate method of reimbursement for each group.

Under Method One, as described in 114.2 CMR 5.09 (3) (see Appendix 1), providers will be reimbursed the following allowable base year costs: depreciation, interest, real estate taxes, the non-income portion of the Massachusetts corporate excise tax, building insurance and equipment rental. Under Method One, providers will also receive the Equity and Use and Occupancy Allowance as described in 114.2 CMR 5.10 (see Appendix 1).

Under Method Two, as described in 114.2 CMR 5.09(4) (see Appendix 1). providers will receive a capital allowance in lieu of all capital and other fixed costs. For rates effective January 1, 1997, the allowance shall be set at $5.61 per diem. ***The capital allowance of $ 5.61 is the 1994 median capital cost of all nursing facilities, excluding those outliers above the 95th percentile.*** However, transition period allowance rules apply for rates effective January 1, 1997. Any facility that has base year capital cost per diem that is greater than the allowance of $5.61 per diem shall have its allowance calculated as set forth in 114.2 CMR 5.09(4)(b)2. (see Appendix 1). Any facility that has base year capital cost per diem that is less than the allowance of $5.61 per diem shall have its allowance calculated as set forth in 114.2 CMR 5.09(4)(b)3. (see Appendix 1).

The Division of Health Care Finance and Policy will calculate allowable Capital and Other Fixed Costs using Method One for a nursing facility which:

1. was operational in 1995 and does not request an Administrative Adjustment for a Substantial Capital Expenditure or Major Addition; or

2. opened on or after January 1, 1996 pursuant to a Determination of Need approved by the Department of Public Health by March 7, 1996; or

3. requested an Administrative Adjustment for a Substantial Capital Expenditure on or after January 1, 1996 pursuant to a Determination of Need or Final Plan approved by the Department of Public Health by March 7, 1996; or

4. requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under 105 CMR 100.505(a)(4).

The Division of Health Care Finance and Policy will calculate allowable Capital and Other Fixed Costs using Method Two for a nursing facility which opened after January 1, 1996 or requested an Administrative Adjustment for a Substantial Capital Expenditure pursuant to a Determination of Need or Final Plan either issued or transferred after March 7, 1996.

A substantial capital expenditure is defined as that which involves physical changes or alterations which change the size and/or functions of a room or otherwise requires prior approval and plan review by the DPH pursuant to 105 CMR 150.017 (A) New Construction, Alterations, and Conversions.

C. Non-Allowable Costs

Non-allowable costs are those costs which are: Non-reimbursable, reimbursed through an allowance, or services billed directly. A description of each is provided in 114.2 CMR 5.04(7)(a)(b)&(c).

D. General Cost Principles

For rate setting purposes, a cost must satisfy, at a minimum, the following criteria:

(1) The cost is ordinary, necessary and directly related to the care of publicly-aided patients;
(2) the cost adheres to the prudent buyer concept;
(3) the cost is for goods or services actually provided in the nursing home; and,
(4) the cost effect of transactions that have the effect of circumventing these rules are not allowable under the principle that the substance of the transaction shall prevail over form.

1. Special Provisions

(a). Principles Governing Cost Splitting. Any cost which is split across two or more accounts on the cost report(s) shall be supported by adequate documentation. Adequate documentation for personnel costs that are split shall be defined as follows: complete and detailed time records such as time cards or sheets, recorded on an individual basis,

and supporting the splitting of the personnel costs among the accounts; as well as work schedules and job descriptions. Each account impacted by such cost splitting shall be identified and the cost splitting fully explained in the Footnotes and Explanation schedule of the cost report. Cost splitting of certain accounts is prohibited as noted throughout these regulations.

(b). Limitation on Rental and Leasehold Expenses. A nursing facility's reasonable rental and leasehold expenses for land, building and equipment shall be allowed, but limited to the lower of: average rental or ownership costs of comparable providers, or the reasonable and necessary costs of the provider and lessor which shall include interest, depreciation, real property taxes and property insurance. Proprietary lessors may be allowed a return on Average Equity Capital relative only to the nursing facility, if it would have been allowed had the provider owned the facility. Rental and leasehold expenses incurred by the nursing facility for items which are not physically located in the nursing facility shall not be reimbursed as fixed and shall be covered by the Administrative and General Allowance. Providers who rent or lease incidental office equipment which is located at the facility shall have such rent allowed as a reasonable operating cost
subject to the prudent Buyer Concept provided that such rental is necessary and contributes to provider efficiency.

©. Rent Based on Income. Additional rental payments or charges based upon receipts or income shall not be considered as additional rental expense.

(d). Other special provisions including Accrued Expenses, Employee Benefits, Equipment Rental, Expenses which Generate Income Payments to Related Parties Services of Non-Paid Workers and Therapy Services - Indirect are described in 114.2 CMR 5.04 (8) (a)-(g) (see Appendix 1).

E. Rate Limitations

1. Medicare Upper Limit of Payment

No weighted average prospective rate of payment established under 114.2 CMR 5.00 et seq. (see Appendix 1) shall exceed the amount that can be reasonably estimated to be paid for these services under Medicare principles of reimbursement. An adjustment will be made only to the extent the costs are reasonable and attributable to the circumstances specified under the Medicare principles and separately identified and verified by the provider.

2. Private Rate Limitation

No prospective rate of payment established under 114.2 CMR 5.00 shall exceed the rate charged by the provider to private patients for the same

or similar services and accommodations. The limitation shall not apply to that portion of prospective rates established for Patient Protector Receivers appointed pursuant to M.G.L. c. 111, s.72N et seq. (see Appendix 6).

a. Methodology

The Division of Health Care Finance and Policy in calculating the private rate limitation shall:

i. determine the weighted average Publicly-Aided patient rate for the Base Year and compare it to the average private rate for the same period, as reported in the cost report for the Base Year.

ii. If a facility's weighted average prospective rate for its Publicly-Aided Patients is greater than the average rate charged by the provider to private patients, the provider may produce justification for such lower rate for private patients before the limitation is applied. Such justification shall include quarterly Management Minute Questionnaires for all private patients. If the provider can classify the private patients into one of the ten case-mix categories, the rate limitation will be the prospective rate for Publicly-Aided Patients as established by the Division of Health Care Finance and Policy for that case-mix category rather than the weighted average rate for all Publicly-Aided patients.

b. Failure to Meet the Rate Limitation

When a long-term care provider fails to satisfy the requirement for rates charged to private patients, the Division of Health Care Finance and Policy shall multiply the difference between the weighted average rate for Publicly-Aided Patients and the average rate charged to private patients by the number of patient days for those discounted private patients to determine the aggregate difference.

F. Audits

Costs and expenses used to calculate the prospective rate of payment shall be established on the basis of a comprehensive desk audit. In addition, whenever possible, the Division of Health Care Finance and Policy will also conduct on-site field audits to ensure the accuracy of claims for reimbursement and consistency in reporting. Any record not produced at the request of Division of Health Care Finance and Policy during an audit shall be deemed not to have been maintained and therefore disallowed.